SUMMITSTAGE

Mountain Mobility
General Information
(Please keep for your records)

The information obtained in this application is confidential and will be used by Summit Stage Mountain Mobility to determine your eligibility for transportation services. Information regarding your functional ability may be shared with another transit agency if this is required to determine eligibility in that system. Your information will not be provided to any other person or agency. For us to best serve you, we may need to schedule an interview with you to fully understand the information provided in your application.

Please fill out the following application with as much detail as possible. **You and your health care professional will need to sign the application before submitting.** Once submitted your application will be reviewed promptly and we will contact you as soon as possible to let you know when a decision has been made. **Please save the "Guidelines for Using Mountain Mobility Service".** It is your responsibility to follow these guidelines. If you do not understand them please ask for a better explanation.

ADA Para-Transit Eligibility

The American's with Disabilities Act (ADA) requires communities with fixed route transportation systems to provide para-transit service for qualified individuals with disabilities who are unable to ride the fixed route system. Individuals with disabilities who are not able to board/disembark or ride the fixed route transportation may be eligible. Additionally, individuals who are unable to reach a fixed route established bus stop may be eligible.

222 County Shops Road Frisco, CO 80443
(970) 389-1041 Fax (970) 668-4165

GUIDELINES FOR USING MOUNTAIN MOBILITY SERVICE

The following guidelines are meant to clarify the rules for para-transit clients.

- **Para-transit service is an "origin to destination" service. Drivers are not permitted to carry any items, or enter your residence or place of business for any reason. Carry on items should be limited to what you can handle yourself.**
- **Please be ready to board the bus 15 minutes prior to your scheduled pick up time. This means having all the items you need ready to go out the door. Drivers may arrive 15 minutes prior to or 15 minutes after your scheduled pick up time.**
- **Drivers are only required to wait 5 minutes beyond their** arrival **time. Please be in the van within this time period so that the driver does not leave you. If a driver is forced to leave you because of tardiness, you will need to arrange for alternate transportation. We will not be able to return to pick you up.**
- **At least** 24 hours **prior notification is required to schedule a trip, change a pick up time, or change the destination for an existing pick up. Changing destinations without the required notice will be marked as a "no show" or cancellation, as appropriate. You may be asked to move your requested pick up time, please be flexible as we are trying to provide service to all the people that need it.**
- **Reservations may be made by phone between the hours of 8:00am and 4:00 pm Monday through Friday at 970-389-1041. Reservations for Monday should be made prior to 4:00PM Friday. You may make a reservation up to 2 weeks in advance. You may submit a "**Schedule Request Form**" for multiple trips up to two weeks in advance (please allow 2 business days for processing this form).**

- **Drivers are not permitted to make any unscheduled or extra stops. Such requests make it difficult to provide service to all clients and to maintain a schedule.**
- **Cancellations must be made at least two hours before your scheduled pick up time at 970-389-1041, or they will be listed as a "no show".** Ten (10) cancellations (or 50% of scheduled trips, whichever occurs first) or four (4) "no shows" in a rolling 30-calendar-day period may result in a review of your riding privileges resulting in a suspension of service. **Continued violation of the "no show" or excessive cancellations policy may result in the revocation of your Mountain Mobility services for a period of up to ninety (90) calendar days.**
- **During busy times we may require you to permit up to one (1) hour between your drop off and pick up times.**
- **If you "no-show" or cancel the first leg of a trip, all later trips scheduled for the day will automatically be cancelled. Each trip that is no-showed is assessed independently in accordance with ADA regulations.**
- **Subscription Service is limited to passengers traveling to the same place at the same time at least three (3) times a week. We may terminate any Subscription Services that are canceled 50% or more of the time during any thirty (30) calendar day period, or if there is a consistent pattern of cancellations of any part of a subscription.**
- **Disruptive or uncontrollable behavior is cause for suspension of your riding privileges.**

Revised: March 18, 2012

SUMMITSTAGE

MOUNTAIN MOBILITY

Date Filed	___/___/_____

Client Registration and Application for Certification of ADA Para-Transit Eligibility

Client Details	
First Name	_____
Last Name	_____
Mailing Address	_____
City, State	_____ _____
Zip Code	_____
Physical Address	_____
City, State	_____ _____
Zip Code	_____
Date of Birth	_____
Mobile Phone	_____
Home Phone	_____
Work Phone	_____

Emergency Contact	
First Name	_____
Last Name	_____
Address	_____
City, State	_____ _____
Zip Code	_____
Relationship	_____
Phone	_____

Physician Information	
First Name	_____
Last Name	_____
Phone	_____

Disability Information & Certification	
What is your disability?	_____ _____ _____
What prevents use of fixed route service?	_____ _____ _____
Temporary condition?	YES / NO
If yes, how long?	_____

Client Registration and Application for Certification of ADA Para-Transit Eligibility

Cognitive Ability

Give addresses and phone numbers on request?	YES / NO
Recognize a destination or landmark?	YES / NO
Deal with unexpected situations or changes in routine?	YES / NO
Ask for, understand and follow directions?	YES / NO
If no, why not	_____
	_____
Safely and effectively travel through crowded and/or complex facilities?	YES / NO
Any other special needs or comments?	_____
	_____
	_____
	_____

Mobility Information

Check if needed for mobility	_____	Wheelchair, Manual
	_____	Wheelchair, Electric
	_____	Powered Scooter
	_____	Cane
	_____	Crutches
	_____	Walker
	_____	Guide Dog
	_____	Other
Do you carry oxygen?	YES / NO	
Do you require a Personal Care Attendant when in transit?	YES / NO	
What types of mobility problems do you have?	_____	
	_____	
Does weather affect your mobility?	YES / NO	

Client Registration and Application for Certification of ADA Para-Transit Eligibility

Please list names and address of the destinations for which you think you need para-transit.

Destination

_____

Address

_____

Reason why fixed route service cannot be used

_____

_____

_____

Destination

_____

Address
_____

Reason why fixed route service cannot be used
_____

_____
_____

Destination
_____

Address
_____

Reason why fixed route service cannot be used
_____

_____
_____

Client Certification and Signature

I hereby certify that the information given is correct.

_____

Printed Name: _____

Date: _____

MOUNTAIN MOBILITY ELIGIBILITY APPLICATION PROFESSIONAL VERIFICATION

SECTION A

This portion of your Americans with Disabilities Act (ADA) paratransit application requires information from a professional you identify as being familiar with your disability/health condition.

Here is what you need to do:

1. **Complete and sign** the authorization form (Section B).Keep Section A for your future reference.

2. **Send** the completed authorization form (Section B) and the Professional Verification Form (Section C) **to the professional you have identified.**

3. The professional will send Section B and Section C back to you.

4. You need to *return the following to Mountain Mobility*

    - The ADA Paratransit Application
    - Section B of this form
    - Section C of this form

Mail To: ***Mountain Mobility***
P O Box 2179
Frisco, Co 80443

Incomplete applications will be returned to you

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SECTION A KEEP THIS SHEET FOR YOUR REFERENCE

How long does the application take?

Once all required information is received, you will be notified within 21 days regarding your eligibility status or if you need to come in for an in person interview.
There are several things you can do to help speed up the process. Be sure you have answered all the questions on the application form, signed the application, and have included the application and Sections B & C.
Applications that do not include all three (3) sections will be considered incomplete and will be returned to you. **Incomplete applications will be returned one (1) time. If the same incomplete packet is received again by Mountain Mobility it will be discarded and applicants will need to start the process over.**

Who qualifies as a professional?

It is important that you select a professional who is familiar with your disability/health condition and your functional abilities and limitations. Make sure that your professional meets the criteria necessary to determine your eligibility. Mountain Mobility will accept information from one of the following professionals:

- Physician or registered nurse
- Licensed independent clinical social worker
- Psychologist/psychiatrist
- Occupational or physical therapist
- Certified rehabilitation counselor
- Certified orientation & mobility specialist
- Certified recreational therapist
- Speech language pathologist

Why is an Authorization Release form necessary?

An applicant's authorization is required before the professional can release information to Mountain Mobility. The information is deemed private and is only used in assisting us in determining an applicant's ADA paratransit eligibility.

MOUNTAIN MOBILITY

Instructions for the Authorization

1. **Complete and sign** the *Authorization to Release Information (Section B).* **Keep** (*Section B)* for your future reference.
2. **Send** the completed *Authorization Form (Section B)* and the *Mountain Mobility Professional Verification Form (Section C)* to your designated professional.
3. **Wait** for the professional to return *Sections B and C* to you. Check back with your professional if you do not receive your information.

Put your application form and ***Sections B & C* in the same envelope and mail to:**

Mountain Mobility
P.O. Box 2179
Frisco, Co. 80443

SECTION B Authorization to Release Information

(when complete send to the professional you named)

Applicant's Name: _____
Date of Birth: _____/_____/_____
Applicant's Address: _____ Apt #: _____
City: _____State: ___ Zip Code:_____
Applicant's Telephone Number: (____) _____

I authorize the following professional to release to Mountain Mobility specific information as requested. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow that professional listed below to release information described for six months after the date appearing below.

Name of Professional: _____Title: _____

*Applicant's Signature:*_____ *Date:*_____

Guardian's signature required if the applicant is not his/her own guardian,

*Guardian's Signature*_____ *Date:*_____

MOUNTAIN MOBILITY

SECTION C Mountain Mobility Professional Verification Form

Dear Health Care Professional,

You are being asked to provide information regarding this individual's disability. The Federal Law is very specific about ADA paratransit eligibility. The law restricts eligibility to individuals who:

1. as a result of their disability, cannot board, ride, or disembark from a regular fixed route bus, or:
2. have a specific impairment-related condition which prevents them from getting to or from a bus stop.

PLEASE NOTE: This **does not** include persons who find it **difficult** or **uncomfortable** to get to and from bus stops.

In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

This section must be filled out for all applicants

GENERAL INFORMATION

- Describe diagnosed disability you are currently treating this individual for:_____
_____
- Date of onset_____/_____/_____
- Date of last visit____/____/_____
- How long have worked with the individual? Since ____/____/_____
- Is disability temporary____ or permanent____?

  If permanent is disability progressive? Yes___ No ___
  If temporary please give best estimate of rate of recovery. <6 mos.__ >6 mos.__ >1year__
- Is therapy part of treatment? Yes___ No ___If yes give brief description _____
_____
- Do Alpine conditions affect the individual? (Ex. Ice, snow, slippery conditions)Yes__ No__ If yes how so?_____
_____
- Do temperature extremes affect the individual? (Ex. Heat index of >85 degrees or wind chill < 10 degrees) Yes___ No___ If yes, how so?_____
_____
- Please list all medications._____
_____
_____
- Is this individual compliant with taking medications? Yes___ No___
- Does the individual currently use regular route public transportation? Yes___ No___ Not Sure___
- Is the individual's judgment impaired? Yes___ No__
- Can the individual walk? Yes___ No___

Does the individual use a mobility aid? Yes___ No___ Please list_____

This section must be filled out for all applicants

GENERAL INFORMATION *Cont'd*

- How long has the individual been using the device(s)?
  _____

- How far can the individual walk? (With mobility device if applicable)
  3 blocks___ 6 blocks___ 9 blocks___ < 3 blocks___
- With treatment/therapy will this distance increase? Yes___ No___
- Please indicate the expected distance after treatment/therapy :
  3 blocks___ 6 blocks___ 9 blocks___ < 3 Blocks ___

  - Give best estimate of length of time required to achieve this improvement.
    _____

Please complete only those sections that apply to this individual

NEUROLOGICAL IMPAIRMENT/HEAD INJURY

- Does the individual experience seizures? Yes__ No __ Date of last seizure ___/___/____ Please give no. of seizures___ and frequency___
  _____
- Is the individual's judgment impaired? Yes___ No___
- Is behavioral inhibition impaired? Yes___ No___
- Does judgment and inhibition impairment prevent the individual from independently traveling outside the home or immediate environment? Yes___ No___
- When traveling independently does the individual have the ability to: (check all that apply)
  Get help if lost___ Recognize & avoid danger___ Cross streets safely___ Follow written directions___ Communicate needs___ Process information___ Understand and follow schedule to get to places on time___

VISUAL IMPAIRMENT * Fill in if applicable

- **Please provide visual acuity measurements and visual field readings for both eyes.**
  ***OS: _____ *OD_____**
- Does the individual require any accommodations, adaptations, low vision aids, etc.?

Please list:_____

- How does the individual's visual impairment affect their ability to move about in the environment? _____
  _____
  _____

- Has the individual received any orientation & mobility (O& M) training? Yes___ No___

EMOTIONAL/BEHAVIOR ISSUES

- Does the individual experience any of the following : auditory hallucinations _____ visual hallucinations_____ delusions _____
- Does this prevent the individual from being oriented to person, place, and time? Yes___ No___
- Is the individual currently being treated for any of the following: anxiety__ depression__ Panic attacks__ schizophrenia__ other__
- For anxiety attacks please indicate on average the frequency and length of panic attacks. Per day____ per week____ per month____ per year____ approx. duration____
- What technique(s) and/or skills is the individual utilizing to assist in coping with the above issue(s)? visualization__ relaxation techniques__ positive self talk__ aroma therapy __ other__
- Are these techniques effective in reducing symptoms? Yes__ No__

COGNITIVE/MENTAL IMPAIRMENTS * Fill in if applicable

- Please describe the functional limitations caused by this impairment._____

_____

_____

- Is the individual impaired? Yes___ No ___
- If yes, please describe to what extent or give an example. _____

_____

***Please list IQ score and GAF score if known. IQ=____ GAF= _____**

- Is the individual able to live independently/ Yes___ No ___

Additional Comments:

_____

_____

Mountain mobility staff will make the final determination of the applicant's eligibility

*Doctor/ Health Care Professional Signature:*_____

Please Return Form to Applicant **PLEASE PRINT so that we may contact you if needed**

Name of Professional:_____Date:___/___/____

Title: _____

Street Address_____

City_____ State ___ Zip Code_____

Telephone Number:_____ Fax:_____